Wisconsin Department of Regulation & Licensing

Mail To: **P.O. Box 8935**
Madison, WI 53708-8935
1400 E. Washington Avenue
Madison, WI 53703
FAX #: (608) 261-7083
Phone #: **(608) 266-2112**
E-Mail: web@drl.state.wi.us
Website: http://drl.wi.gov

BOARD OF NURSING

APPLICATION FOR CERTIFICATION AS AN ADVANCED PRACTICE NURSE PRESCRIBER

Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

PLEASE TYPE OR PRINT IN INK ☐ Your name and address are available to the public.
Check box if you wish your name & address withheld from lists of 10 or more credential holders (sec. 440.14, Stats.)

Last Name	First Name	MI	Former / Maiden Name(s)

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth
_____ _____ _____
month day year

Daytime Telephone Number
( ) _____ - _____

Ethnic/gender status information is optional.

Sex: ☐ M ☐ F

Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

Have you ever held a license/credential in the state of Wisconsin? **_____Yes _____No (please indicate)**
If yes, provide your Wisconsin license/credential number. _____

Nursing School: _____

School Address: _____
(City) (State)

Date of Diploma: _____
month/day/year

Degree: _____

What is your state of primary residence?

_____

If not Wisconsin, do you plan to move to Wisconsin and take up primary residence?
☐ Yes ☐ No

APPLICATION FEES Please check applicable blank(s): (Make check payable to Department of Regulation and Licensing and attach to application.)

____ $ 53.00 Initial Credential Fee
$ 57.00 State Law Exam
$110.00 Total fee

For Receipting Use Only

Wisconsin Department of Regulation & Licensing

APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

Fee(s) attached to this application (Form #2124).

Verification of current national certification

Certification of masters degree (Form #2367) (If you received national certification after 7/1/98)

Wisconsin Statutes and Rules Examination (Your logon ID and password will be sent to you after we receive your application and fee)

Evidence of malpractice insurance coverage.

Letters from all state boards where credentialed (includes active and inactive credentials) as an advanced practice nurse prescriber.

Copies of malpractice suit(s). Court documents with allegations and settlement (if applicable).

Social Security Form (page 6 of 6 Form 2124)

IS NAME ON ALL CREDENTIALS THE SAME? IF NOT, SUBMIT CERTIFIED COPY OF MARRIAGE CERTIFICATE, DIVORCE DECREE, ETC.

I AM CURRENTLY CERTIFIED AS: (check one)

- ❑ Nurse Practitioner - Specialty: _____
- ❑ Clinical Nurse Specialist - Specialty: _____
- ❑ Certified Registered Nurse Anesthetist
- ❑ Certified Nurse-Midwife

I HOLD CURRENT CERTIFICATION BY: (Check all that apply & submit proof)

❑ American Academy of Nurse Practitioners	Cert No.	_____	Grant Date	_____	Exp. Date	_____
❑ American Assoc. of Nurse Anesthetists	Cert No.	_____	Grant Date	_____	Exp. Date	_____
❑ American College of Nurse-Midwives	Cert No.	_____	Grant Date	_____	Exp. Date	_____
❑ ANA Credentialing Center	Cert No.	_____	Grant Date	_____	Exp. Date	_____
❑ ANCC Credentialing Center	Cert No.	_____	Grant Date	_____	Exp. Date	_____
❑ Nat'l Certification Board of Pediatric Nurse Practitioners & Nurses	Cert. No.	_____	Grant Date	_____	Exp. Date	_____
❑ Nat'l Certification Corporation for OB, GYN & Neonatal Nursing Specialties	Cert No.	_____	Grant Date	_____	Exp. Date	_____
❑ Am. Assn. of Critical Care Nurses Cert. Corp., (949) 362-2050, Clinical Nurse Specialist (Acute and Critical Care)	Cert No.	_____	Grant Date	_____	Exp. Date	_____

"Clinical pharmacology/therapeutics," as defined in sec. N 8.02(4), Wis. Admin. Code, means the identification of individual and classes of drugs, their indications and contraindications, their likelihood of success, their side-effects and their interactions, as well as, clinical judgment skills and decision-making, based on thorough interviewing, history-taking, physical assessment, test selection and interpretation, pathophysiology, epidemiology, diagnostic reasoning, differentiation of conditions, treatment decisions, case evaluation and non-pharmacologic interventions.

I HAVE COMPLETED AT LEAST 45 CONTACT HOURS IN CLINICAL PHARMACOLOGY/THERAPEUTICS WITHIN 3 YEARS PRECEDING THIS APPLICATION. (Contact hours for academic courses are assigned as follows: 1 semester credit = 15 contact hours; 1 quarter credit = 10 contact hours)

❑ YES ❑ NO ATTACH PHOTOCOPIES FOR CERTIFICATES OF COMPLETION OR TRANSCRIPTS OF COURSES ATTENDED WITHIN THE LAST 3 YEARS INCLUDING THE DATE WHICH THE COURSES WERE TAKEN.

ARE YOU OR HAVE YOU EVER BEEN CREDENTIALED IN THE FOLLOWING STATES (UNLIMITED) AS AN ADVANCED PRACTICE NURSE PRESCRIBER:

By Written Exam: _____

By Endorsement/Reciprocity: _____

YOU ARE REQUIRED TO HAVE EACH STATE BOARD IN WHICH YOU HAVE EVER BEEN CREDENTIALED SUBMIT LETTERS OF VERIFICATION TO THE WISCONSIN BOARD OF NURSING. THE LETTERS MUST INDICATE YOUR DATE OF BIRTH, CREDENTIAL NUMBER, DATE OF ISSUANCE, AND A STATEMENT REGARDING DISCIPLINARY ACTIONS. THESE LETTERS WILL BE REQUIRED IN ORDER TO COMPLETE YOUR APPLICATION FOR LICENSURE.

Wisconsin Department of Regulation & Licensing

ANSWER THE FOLLOWING QUESTIONS: (Attach additional sheets if necessary.)

		YES	NO
1.	Do you hold a current Wisconsin License as a Registered Nurse? License # _____ Expiration Date _____	❑	❑
2.	Do you have current **personal** liability malpractice insurance coverage? **If yes, submit a copy of your certificate of insurance showing the limits of personal liability coverage, including dates of coverage.**	❑	❑
3.	Do you have current **group** malpractice liability insurance coverage? **If yes, submit a copy of your certificate of insurance showing the limits of personal liability coverage, including dates of coverage and complete the certification form #2157 enclosed.**	❑	❑
4.	Have you ever had a finding of abuse or misappropriation placed against you on the Wisconsin Nurse Aide Registry of the Department of Health & Social Services or any other state's registry? **If yes, give details on an attached sheet, including date and type of action.**	❑	❑
5.	Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health and Family Services regarding communicable diseases?	❑	❑
6	Have you ever surrendered, resigned, cancelled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? **If yes, give details on an attached sheet, including the name of the profession and the agency.**	❑	❑
7.	Have you ever failed to pass any state board examination, providence of Canada examination, or NCLEX examination? **If yes, give details on an attached sheet.**	❑	❑
8.	Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation, revocation? **If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.**	❑	❑
9.	Is disciplinary action pending against you in any jurisdiction? **If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.**	❑	❑
10.	Do you have any felony or misdemeanor charges pending against you? **If yes, attach a sheet providing details about the pending charge, copy of the court documents and status of the charge. (Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges.)**	❑	❑
11.	Have you ever been convicted of a misdemeanor or a felony? **If yes, attach a sheet providing details about the crime, including date of conviction, penalty and a copy of the court documents. (Please do not give details on minor traffic convictions, but do include information relating to Driving While Intoxicated (DWI) charges.)**	❑	❑
12.	Are you incarcerated, on probation or on parole for any conviction? **If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.**	❑	❑
13.	Have any suits or claims ever been filed against you as a result of professional services? **If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.**	❑	❑
14.	Are you registered or licensed in any other profession(s)? **If yes, state what profession(s) and in what states(s).**	❑	❑
15.	Have you ever been credentialed under any other name(s)? **If yes, state name(s) credentialed under.**	❑	❑
16.	Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? **If yes, give details on an attached sheet.**	❑	❑

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For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice as an advanced practice nurse prescriber" is to be construed to include all of the following:

1. The cognitive capacity to exercise reasoned advanced practice nurse prescriber judgments and to learn and keep abreast of advanced practice nurse prescriber developments; and
2. The ability to communicate those judgments and advanced practice nurse prescriber information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform advanced practice nurse prescriber tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

		YES	NO
17.	Do you have a medical condition which in any way impairs or limits your ability to practice as an advanced practice nurse prescriber with reasonable skill and safety? **If yes, please explain.**	❑	❑
18.	Does your use of chemical substance(s) in any way impair or limit your ability to practice as an advanced practice nurse prescriber with reasonable skill and safety? **If yes, please explain.**	❑	❑
19.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? **If yes, please explain.**	❑	❑
20.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? **If yes, please explain.**	❑	❑
21.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? **If yes, please explain.**	❑	❑
22.	Are you currently engaged in the illegal use of controlled dangerous substances?	❑	❑
23.	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **If yes, please explain.**	❑	❑

AFFIDAVIT *OF APPLICANT*
(Sign and date <u>in the presence of</u> a notary)

I state that I am the person referred to on this application and that all the answers set forth are each and all strictly true in every respect. I understand that false or forged statements made in connection with this application may be grounds for revocation of my credential. I also understand that if I am issued a credential, failure to comply with the laws or rules of either the Board of Nursing or the Wisconsin Department of Regulation and Licensing will be cause for disciplinary action.

_____
Signature of Applicant

State of _____ County of _____

Subscribed and sworn to before this _____ day of

_____, 20_____, by _____
(Applicant name)

_____
Signature of Notary Public

S E A L

_____
Date Commission Expires

NOTE: This affidavit must be signed by the applicant in the presence of the notary public on the same date.

Wisconsin Department of Regulation & Licensing

SOCIAL SECURITY NUMBER. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.[1] A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

_____

First Name **Middle Initial** **Last Name**

_____

Profession

Date of Birth _____ _____ _____

month day year

☐☐☐ - ☐☐ - ☐☐☐☐

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Workforce Development for purposes of administering the child and spousal support program,[2] to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,[3] and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.[4]

[1] Section 440.03 (11m), Wis. Stats.

[2] Sections 49.22, and 440.13, Wis. Stats.

[3] Section 440.12, Wis. Stats.

[4] Health Insurance Portability and Accountability Act (HIPAA) of 1996

This form is authorized by secs. 440.12 and 440.14, Wis. Stats. Making a false statement in connection with this application may result in revocation or denial.